in the psychological aspects of cystic fibrosis. Dr. Holsclaw's letter is important, and I wonder if you would include it somewhere in your journal because I think it would be of interest to the many readers who have expressed their absorption in this topic.

JOSEPH D. TEICHER, M.D.

(Dr. Holsclaw's letter follows.—Editor)

Dear Doctor Teicher:

I recently had the opportunity to read your article, "Psychological Aspects of Cystic Fibrosis in Children and Adolescents," which appeared in CALIFORNIA MEDICINE, May 1969. I want to compliment you on an excellent summary of a very broad and exceedingly difficult subject. I would suspect that as a result of this publication, you will be called upon in the future to speak about this subject at various conferences, etc. I would like to urge that you include in future presentations some comment about the male sterility which has been recently discovered. As you can well imagine this places an additional psychological burden on the male adolescent with cystic fibrosis. It would seem to me impossible to not have some effect on the adolescent male self-image as well as his projected plans for future marriage and family. I suppose this is a mixed blessing, however, in the sense that the male sterility may be nature's contraceptive. This would lend even further emphasis to your closing paragraph concerning the adoption of children by persons with cystic fibrosis.

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DELAYING REPAIR OF RECTOVAGINAL FISTULA

"The rectovaginal fistula is a distressing complication for both the patient and the surgeon. Here I'd like to raise a red flag because there's a great tendency to press for immediate repair, and it seems to me that this is in error. To avoid the possibility of having the fistula recur after the initial attempt to close it, the part of wisdom is to delay that repair until the infection has quieted down. Remember you cannot judge the extent of damage to the rectum by the size of the vaginal opening. The one in the rectal wall is always bigger than the one that you see in the vaginal canal. If it's a particularly large fistula, you may have to wait as long as six months. Usually, they're associated with infection. Unfortunately, the antibiotics are not as useful as you'd like to have them in clearing up any fistulous abscess. So it may be advisable to perform a temporary colostomy—a diverting colostomy . . . with no spill over. In this way, you minimize the contamination for the fecal stream and have some chance of clearing up this infection before you start any attempt at repair. Now whether you do a colostomy or not depends on the extent of the damage and the chances of eliminating the sepsis by any simple means that you might employ.

—LANGDON PARSONS, M.D., Boston

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